F690

(Rev. 229; Issued: 04-25-25; Effective: 04-25-25; Implementation: 04-28-25)

§483.25(e) Incontinence.

§43.25(e)(1) The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that—

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

INTENT

The intent of this requirement is to ensure that:

- Each resident who is continent of bladder receives the necessary services and assistance to maintain continence, unless it is clinically not possible.

- Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible;

- An indwelling catheter is not used unless there is valid medical justification for catheterization and the catheter is discontinued as soon as clinically warranted;

- A resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible;

- Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the indwelling catheter; and

- A resident with fecal incontinence is identified, assessed and provided appropriate treatment and services to restore as much normal bowel function as possible, unless it is not clinically possible;

NOTE: F690 includes the appropriate treatment and services to restore bowel function for a resident with fecal incontinence, however, for concerns related to bowel management (such as constipation, fecal impaction), refer to F684 – Quality of care

DEFINITIONS

"Bacteremia" is the presence of bacteria in the bloodstream.

"Bacteriuria" is defined as the presence of bacteria in the urine.

"Continence" refers to any void that occurs voluntarily, or as the result of prompted, assisted, or scheduled use of the bathroom.

"Sepsis" is the body's overwhelming and life-threatening response to an infection which can lead to tissue damage, organ failure, and death.

"Urinary Incontinence" is the involuntary loss or leakage of urine.

"Urinary Retention" is the inability to completely empty the urinary bladder by micturition.

"Urinary Tract Infection (UTI)" is a clinically detectable condition associated with invasion by disease causing microorganisms of some part of the urinary tract, including the urethra (urethritis), bladder (cystitis), ureters (ureteritis), and/or kidney (pyelonephritis). An infection of the urethra or bladder is classified as a lower tract UTI and infection involving the ureter or kidney is classified as an upper tract UTI.

GUIDANCE §483.25(e)

A resident who is continent of bladder on admission must receive care, including assistance, and services to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. If a resident is admitted with incontinence of bladder, he/she receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Urinary incontinence generally involves a number of transitory or progressive factors that affect the bladder and/or the urethral sphincter. Any condition, medication, or factor that affects lower urinary tract function, bladder capacity, urination, or the ability to toilet can predispose residents to urinary incontinence and may contribute to incomplete bladder emptying.

Assessment

A resident should be assessed at admission regarding continence status and whenever there is a change in urinary tract function, such as if a resident is admitted who is continent of urine, and subsequently becomes incontinent. The identification of reversible and irreversible (e.g., bladder tumors, spinal cord disease) causes of incontinence, including the type of incontinence, provides direction for the development of appropriate interventions. It is important that staff, when completing the comprehensive assessment, consider the following:

- Prior history of bladder functioning, including status of continence, history of urinary incontinence, including onset, duration and characteristics, precipitants of urinary incontinence, associated symptoms (e.g., dysuria, polyuria, hesitancy) and previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI;

- Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and, for those already experiencing urinary incontinence, voiding patterns over several days;

- Medication review, particularly those that might affect continence, such as medications with anticholinergic properties (may cause urinary retention and possible overflow incontinence), sedative/hypnotics (may cause sedation leading to functional incontinence), diuretics (may cause urgency, frequency, overflow incontinence), narcotics, alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women) calcium channel blockers (may cause urinary retention);

- Patterns of fluid intake, such as amounts, time of day, alterations and potential complications, such as decreased or increased urine output;

- Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake);

- Pelvic and rectal examination to identify physical features that may directly affect urinary continence, such as prolapsed uterus or bladder, prostate enlargement, significant constipation or fecal impaction, use of a urinary catheter, atrophic vaginitis, distended bladder, or bladder spasms;

- Functional and cognitive capabilities that could enhance urinary continence and limitations that could adversely affect continence, such as impaired cognitive

function or dementia, impaired immobility, decreased manual dexterity, the need for task segmentation, decreased upper and lower extremity muscle strength, decreased vision, pain with movement;

- Type and frequency of physical assistance necessary to assist the resident to access the toilet, commode, urinal, etc. and the types of prompting needed to encourage urination;

- Pertinent diagnoses such as congestive heart failure, stroke, diabetes mellitus, obesity, and neurological disorders (e.g., Multiple Sclerosis, Parkinson's Disease or tumors) that could affect the urinary tract or its function);
- Identification of and/or potential of developing complications such as skin irritation or breakdown;

- Tests or studies indicated to identify the type(s) of urinary incontinence (e.g., post-void residual(s) for residents who have, or are at risk of, urinary retention, results of any urine culture if the resident has clinically significant systemic or urinary symptoms), or evaluations assessing the resident's readiness for bladder rehabilitation programs; and

- Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet (e.g., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commodes, and availability of urinals, use of bed rails or restraints, or fear of falling).

Types of Urinary Incontinence

Identifying the nature of the incontinence is a key aspect of the assessment and helps identify the appropriate program/interventions to address incontinence. There are several types of urinary incontinence, and the individual resident may experience more than one type at a time. Some of the more common types include:

- **Urge Incontinence** is associated with detrusor muscle over activity (excessive contraction of the smooth muscle in the wall of the urinary bladder) resulting in a sudden, strong urge (also known as urgency) to expel moderate to large amounts of urine before the bladder is full). It is characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis). It may be age-related or have neurological causes (e.g., stroke, diabetes mellitus, Parkinson's disease, multiple sclerosis) or other causes such as bladder infection, urethral irritation, etc. The resident can feel the need to void, but is unable to inhibit voiding long enough to reach and sit on the commode. It is the most common cause of urinary incontinence in elderly persons.

- **Stress Incontinence** (outlet incompetence) is associated with impaired urethral closure (malfunction of the urethral sphincter) which allows small amounts of urine leakage when intra-abdominal pressure on the bladder is increased by

sneezing, coughing, laughing, lifting, standing from a sitting position, climbing stairs, etc. Urine leakage results from an increase in intra-abdominal pressure on a bladder that is not over distended and is not the result of detrusor contractions. It is the second most common type of urinary incontinence in older women.

- **Mixed Incontinence** is the combination of urge incontinence and stress incontinence. Many elderly persons (especially women) will experience symptoms of both urge and stress.

- **Overflow Incontinence** is associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended from urine retention. Symptoms of overflow incontinence may include: weak stream, hesitancy, or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling. Urine retention may result from outlet obstruction (e.g., benign prostatic hypertrophy (BPH), prostate cancer, and urethral stricture), hypotonic bladder (detrusor under activity) or both. Hypotonic bladder may be caused by outlet obstruction, impaired or absent contractility of the bladder (neurogenic bladder) or other causes. Neurogenic bladder may also result from neurological conditions such as diabetes mellitus, spinal cord injury, or pelvic nerve damage from surgery or radiation therapy. In overflow incontinence, post void residual (PVR) volume (the amount of urine remaining in the bladder within 5 to 10 minutes following urination) exceeds 200 milliliters (ml). Normal PVR is usually 50 ml. or less. A PVR of 150 to 200 may suggest a need for retesting to determine if this finding is clinically significant. Overflow incontinence may mimic urge or stress incontinence but is less common than either of those.

- **Functional Incontinence** refers to loss of urine that occurs in a resident whose urinary tract function is sufficiently intact that he/she should be able to maintain continence, but who cannot remain continent because of external factors other than inherently abnormal urinary tract function. Examples may include the failure of staff to respond to a request for assistance to the toilet, or the inability to utilize the toilet facilities in time. It may also be related to:

    - Physical weakness or poor mobility/dexterity (e.g., due to poor eyesight, arthritis, deconditioning, stroke, contracture);

    - Cognitive problems (e.g., confusion, dementia, unwillingness to toilet);
    - Medications (e.g., anti-cholinergics, diuretics); or

    - Environmental impediments including excessive distance from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets that are difficult to access.

      Refer to §483.10(e) (3), F558, Accommodation of Needs for issues regarding unmet environmental needs (e.g., handicap toilet, lighting, assistive devices.

NOTE: Treating the physiological causes of incontinence, without attending to functional components that may have an impact on the resident's continence, may fail to solve the incontinence problem.

- **Transient Incontinence** refers to temporary or occasional incontinence that may be related to a variety of causes, for example: delirium, infection, atrophic urethritis or vaginitis, some pharmaceuticals (such as sedatives/hypnotics, diuretics, anticholinergic agents), increased urine production, restricted mobility or fecal impaction. The incontinence is transient because it is related to a potentially improvable or reversible cause.

Interventions

A number of factors may contribute to the development of incontinence, or decline or lack of improvement in urinary continence, such as an underlying medical condition.an inaccurate assessment of the resident's type of incontinence, or lack of knowledge about the resident's voiding patterns. This may contribute to inappropriate interventions or unnecessary use of an indwelling catheter. Facility practices that may promote achieving the highest practicable level of functioning, may prevent the development of incontinence, or minimize a decline or lack of improvement in degree of continence include providing treatment and services to address factors that are potentially modifiable, such as:

- Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc.;

- Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet);

- Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion);

- Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and

- Implementing a fluid and/or bowel management program to meet the assessed needs.

Options for managing urinary incontinence in nursing home residents include primarily behavioral programs and medication therapy. Other measures and supportive devices used in the management of urinary incontinence and/or urinary retention may include intermittent catheterization; pelvic organ support devices (pessaries); biofeedback; the

use of incontinence products, garments and an external collection system for men and women; and environmental accommodation and/or modification.

Behavioral Programs

Interventions involving the use of behavioral programs are among the least invasive approaches to address urinary incontinence and have no known adverse complications. Behavior programs involve efforts to modify the resident's behavior and/or environment. Critical aspects of a successful behavioral program include education of the caregiver and the resident, availability of the staff and the consistent implementation of the interventions.

NOTE: It is important for the comprehensive assessment to identify the essential skills the resident must possess, such as the resident's ability to: comprehend and follow instructions; identify urinary urge; control the urge to void until reaching a toilet; and/or respond to prompts to void. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate planning care to avoid or reduce the frequency of episodes.

Programs that require the resident's cooperation and motivation in order for learning and practice to occur include the following:

- **"Bladder Rehabilitation/Bladder Retraining**" is a behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void. Depending upon the resident's successful ability to control the urge to void, the intervals between voiding may be increased progressively. Bladder training generally consists of education, scheduled voiding with systematic delay of voiding, and positive reinforcement. This program is difficult to implement in cognitively impaired residents and may not be successful in frail, elderly, or dependent residents. The resident who may be appropriate for a bladder rehabilitation (retraining) program is usually fairly independent in activities of daily living, has occasional incontinence, is aware of the need to urinate (void), may wear incontinence products for episodic urine leakage, and has a goal to maintain his/her highest level of continence and decrease urine leakage. Successful bladder retraining usually takes at least several weeks. Residents who are assessed with urge or mixed incontinence and are cognitively intact may be candidates for bladder retraining. This is not to be confused with habit training/scheduled voiding (see below); and

- **"Pelvic Floor Muscle Rehabilitation**," also called Kegel and pelvic floor muscle exercise, is performed to strengthen the voluntary periuretheral and perivaginal muscles that contribute to the closing force of the urethra and the support of the pelvic organs. These exercises are helpful in dealing with urge and stress incontinence. Pelvic floor muscle exercises (PFME) strengthen the muscular components of urethral supports and are the cornerstone of noninvasive treatment

of stress urinary incontinence. PFME requires residents who are able and willing to participate and the implementation of careful instructions and monitoring provided by the facility. Poor resident adherence to the exercises may occur even with close monitoring.

Programs that are dependent on staff involvement and assistance, as opposed to resident function, include the following:

- **"Prompted Voiding**" is a behavioral technique appropriate for use with dependent or more cognitively impaired residents. Prompted voiding has three components: regular monitoring with encouragement to report continence status; prompting to toilet on a scheduled basis; and praise and positive feedback when the resident is continent and attempts to toilet. These methods require training, motivation and continued effort by the resident and caregivers to ensure continued success. Prompted voiding focuses on teaching the resident, who is incontinent, to recognize bladder fullness or the need to void, to ask for help, or to respond when prompted to toilet.

  Residents who are assessed with urge or mixed incontinence and are cognitively impaired may be candidates for prompted voiding. As the resident's cognition changes, the facility should consider other factors, such as mobility, when deciding to conduct a voiding trial to determine feasibility of an ongoing program to use the bathroom; and

- **"Habit Training/Scheduled Voiding**" is a behavioral technique that calls for scheduled use of the bathroom at regular intervals on a planned basis to match the resident's voiding habits. Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges. This is not considered to be a bladder rehabilitation/retraining program. Habit training includes timed voiding with the interval based on the resident's usual voiding schedule or pattern. Scheduled voiding is timed voiding, usually every three to four hours while awake. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs.

Intermittent Catheterization

Sterile insertion and removal of a catheter through the urethra every 3-6 hours for bladder drainage may be appropriate for the management of acute or chronic urinary retention. See additional discussion below in "Catheterization".

Medication Therapy

Medications are often used to treat specific types of incontinence, including stress incontinence and those categories associated with an overactive bladder, which may involve symptoms including urge incontinence, urinary urgency, frequency and nocturia. The current literature identifies classifications and names of medications used for various

types of incontinence. When using medications, potentially problematic anticholinergic and other side effects must be recognized. The use of medication therapy to treat urinary incontinence may not be appropriate for some residents because of potential adverse interactions with their other medications or other co-morbid conditions. The resident/representative must be provided with the risks and benefits of using medications for continence management.

Pessary

A pessary is an intra-vaginal device used to treat pelvic muscle relaxation or prolapse of pelvic organs. Women whose urine retention or urinary incontinence is exacerbated by bladder or uterine prolapse may benefit from placement of a pessary. Female residents may be admitted to the nursing home with a pessary device. The assessment should note whether the resident has a pessary in place or has had a history of successful pessary use. If a pessary is used, the plan of care must address the use, care and ongoing management of the pessary including monitoring for complications.

Absorbent Products, Devices, and External Collection Devices

Absorbent incontinence products include perineal pads or panty liners for slight leakage, undergarments and protective underwear for moderate to heavy leakage, guards and drip collection pouches for men, and products (called adult briefs) for moderate or heavy loss. Absorbent products can be a useful, rational way to manage incontinence; however, every absorbent product has a saturation point. Factors contributing to the selection of the type of product to be used should include the severity of incontinence, gender, fit, and ease of use.

Advantages of using absorbent products to manage urinary incontinence include the ability to contain urine (some may wick the urine away from the skin), provide protection for clothing, and preserve the resident's dignity and comfort.

NOTE: Although many residents have used absorbent products prior to admission to the nursing home and the use of absorbent products may be appropriate, absorbent products should not be used as the primary long term approach to continence management until the resident has been appropriately evaluated and other alternative approaches have been considered.

It is important that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations.

Skin-Related Complications

Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to

damage from friction and shear during repositioning. For a resident with an external catheter, compromise to the skin may also occur.

One form of early skin breakdown is maceration or the softening of tissue by soaking. Macerated skin has a white appearance and a very soft, sometimes "soggy" texture. The persistent exposure of perineal skin to urine and/or feces can irritate the epidermis and can cause severe dermatitis, skin erosion and/or ulcerations. Skin erosion is the loss of some or all of the epidermis (comparable to a deep chemical peel) leaving a slightly depressed area of skin.

Because frequent washing with soap and water can dry the skin, the use of a perineal rinse may be indicated.

CATHETERIZATION

Sections 483.25(e)(2)(i) and (ii), Incontinence, requires that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; or that a resident who enters the facility with an indwelling urinary catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. The facility is responsible for the assessment of the resident at risk for urinary catheterization and the ongoing assessment for the resident who currently has a catheter, including the removal of the catheter as soon as possible when the resident's clinical condition demonstrates the catheter is no longer necessary. While the use of a catheter may promote skin integrity and assessment of output, it is also associated with the increase risk of catheter associated urinary tract infections (CAUTI), including the development of sepsis.

A catheter that is used for appropriate indications and in a dignified manner may enhance an individual's independence and dignity. Conversely, an improperly or indiscreetly used catheter may negatively impact independence and dignity.

NOTE: For concerns related to the care for a resident with a urostomy or nephrostomy, refer to §483.25(f) - Colostomy, urostomy, or ileostomy care at tag F691.

In addition, according to the Centers for Disease Control and Prevention (CDC), the definition of a suprapubic catheter is one that "is surgically inserted into the bladder through an incision above the pubis. For care of a resident with a suprapubic catheter, refer to current professional guidelines.

Assessment

Regardless of the admission status, a comprehensive assessment should address those factors that predispose the resident to the development of urinary incontinence and the use of an indwelling urinary catheter. An admission evaluation of the resident's medical history and a physical examination helps identify the resident at risk for requiring the use

of an indwelling urinary catheter. This evaluation is to include detection of reversible causes of incontinence and identification of individuals with incontinence caused by conditions that may not be reversible, such as bladder tumors and spinal cord diseases.

The assessment of continence/incontinence is based upon a comprehensive, interdisciplinary review and assessment. The comprehensive assessment should include identifying the underlying factors which support the clinical indication for the initiation and continuing need for catheter use, determination of which factors can be modified or reversed (or rationale for why those factors should not be modified), and the development of a plan for removal. The clinician's decision to use an indwelling catheter in the elderly should be based on valid clinical indicators.

For the resident with an indwelling catheter, the facility's documented assessment and staff knowledge of the resident should include information to support the use of an indwelling catheter. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be reserved primarily for short-term decompression of acute urinary retention. The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter; the potential for removal of the catheter; and consideration of complications resulting from the use of an indwelling catheter, such as symptoms of blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort and bleeding.

Intermittent Catheterization

Intermittent catheterization can often manage overflow incontinence effectively. Residents who have new onset incontinence from a transient, hypotonic/atonic bladder (usually seen following indwelling catheterization in the hospital) may benefit from intermittent bladder catheterization until the bladder tone returns (e.g., up to approximately 7 days). A voiding trial and post void residual can help identify when bladder tone has returned.

Indwelling Urinary Catheter Use

If the facility provides care for a resident with an indwelling catheter, in collaboration with the medical director and director of nurses, and based upon current professional standards of practice, resident care policies and procedures must be developed and implemented that address catheter care and services, including but not limited to:

- Documentation of the involvement of the resident and/or resident representative in the discussion of the risks and benefits of the use of a catheter, removal of the catheter when criteria or indication for use is no longer present, and the right to decline the use of the catheter;

- Timely and appropriate assessments related to the indication for use of an indwelling catheter;

- Identification and documentation of clinical indications for the use of a catheter; as well as criteria for the discontinuance of the catheter when the indication for use is no longer present;

- Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures;

- Response of the resident during the use of the catheter; and

- Ongoing monitoring for changes in condition related to potential CAUTI's and recognizing, reporting and addressing such changes.

(See **NOTE** below for examples of clinical indications for use.)

The resident's record must include how and when the resident/representative was involved and informed of care and treatment including the potential use and indications for the need for a catheter, how long use is anticipated, and when and why a catheter must be removed. The resident/representative must be included in the development of the care plan including the use of the catheter and associated interventions. In addition, the resident/representative has the right to decline the treatment. Based on current professional standards of practice, information and education of the resident/representative on the identification of risks and benefits for the use of a catheter must be documented.

Anecdotally, it has been reported that residents or their representatives have requested the use of and/or declined to allow the removal of an indwelling urinary catheter. The record must contain documentation as to why a resident/representative chooses to have or chooses to continue to use a catheter in the absence of clinical indications for use. After determining the reasons, staff and the attending practitioner must document the provision of counseling to assist the resident in understanding the clinical implications and risks associated with the use of a catheter without an indication for continued use. The care plan must be revised to address the education being provided, including interventions to restore as much urinary function as possible without the use of catheter.

Documentation in the resident's record must reflect the attending practitioner's valid clinical indication to support the use of an indwelling catheter.

NOTE: The following Table from the CDC, includes examples for appropriate indications for indwelling catheter use and includes both acute and long term care. This table has been adapted to include only those examples relevant for a long term care setting. For the full table and for guidance related to indwelling catheter management and care refer to: http://www.cdc.gov/hicpac/cauti/02_cauti2009_abbrev.html

A. Examples of Appropriate Indications for Indwelling Urethral Catheter Use

- Resident has acute urinary retention or bladder outlet obstruction;

- Need for accurate measurements of urinary output;
- To assist in healing of open sacral or perineal wounds in incontinent residents;
- Resident requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures); and
- To improve comfort for end of life care, if needed.

B. Examples of Inappropriate Uses of Indwelling Catheters

- As a substitute for nursing care of the resident with incontinence; and
- As a means of obtaining urine for culture or other diagnostic tests when the resident can voluntarily void.

NOTE: These above indications are based on expert consensus.

Additional care practices related to catheterization include:

- Recognizing and assessing for complications and their causes, and maintaining a record of any catheter-related problems;
- Attempts to remove the catheter as soon as possible when no indications exist for its continuing use;
- Monitoring for excessive post void residual, after removing a catheter that was inserted for obstruction or overflow incontinence;
- Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter; and
- Securing the catheter to facilitate flow of urine, preventing kinking of the tubing and position below the level of the bladder. (Also refer to F880 – Infection Control for policies and procedures related to care of the catheter and equipment, such as tubing, bags, etc.).

NOTE: Refer to the CDC site for current information on catheter use, management and care at: http://www.cdc.gov/HAI/ca_uti/uti.html

Catheter-Related Complications

An indwelling catheter may be associated with significant complications, including bacteremia, febrile episodes, bladder stones, fistula formation, erosion of the urethra, epididymitis, chronic renal inflammation and pyelonephritis and sepsis related to urinary

tract infections. In addition, indwelling catheters are prone to blockage. Risk factors for catheter blockage include alkaline urine, poor urine flow, proteinuria, and preexisting bladder stones.

Some residents with indwelling catheters experience persistent leakage around the catheter. Examples of factors that may contribute to leakage include irritation by a large balloon or by catheter materials, excessive catheter diameter, fecal impaction, and improper catheter positioning. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended.
(Refer to: https://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf)

Catheterization is an important, potentially modifiable, risk factor for UTI. The potential for complications can be reduced by:

- Identifying specific clinical indications for the use of an indwelling catheter;
- Assessing whether other treatments and services would appropriately address those conditions; and
- Assessing whether residents are at risk for other possible complications resulting from the continuing use of the catheter, such as obstruction resulting from catheter encrustation, urethral erosion, bladder spasms, hematuria, and leakage around the catheter.

URINARY TRACT INFECTIONS

Catheter-Related Bacteriuria and UTIs

Bacteriuria (e.g., pyuria) alone in a catheterized individual should not be treated with antibiotics. Someone with nonspecific symptoms such as a change in function or mental status, foul smelling or cloudy urine and/or, bacteriuria (e.g. pyuria), does not necessarily warrant antibiotic treatment. The decision to treat a UTI is based upon the attending practitioner conducting a thorough evaluation and assessment of the resident and providing documentation of a rationale for the indication of use of an antibiotic.

NOTE: For a non-catheterized resident with symptoms associated with a UTI, the attending practitioner should order a urine culture prior to the initiation of antibiotic therapy to help guide treatment. According to current standard of practice, an accurate urine culture for a non-catheterized resident should be obtained by a clean catch or mid-stream specimen for residents who are able to follow instructions. For those unable to provide a clean-catch, a specimen may be obtained preferably by a freshly placed condom catheter for males, or in and out catheterization for females or males unable to provide a specimen by a condom catheter. If the resident has a long-term indwelling urethral catheter, a specimen should be obtained from a freshly placed indwelling catheter. Reference - the IDSA Guidelines for Evaluation of Fever and Infection in

Older Adult Residents of Long-Term Care Facilities. (High et al. Clinical Infectious Diseases, 2009:48-149-71).

The surveyor should determine if facility policy for obtaining urine for cultures is based upon current standards of practice, understanding that these standards may be revised and updated over time. The facility should be able to provide the most current standard that supports the policy that they have developed and implemented. (Also refer to F880 Infection Control and F881 for antibiotic stewardship program for infection assessment tools.)

Unnecessary treatment of a UTI with antibiotics may lead to the development of multi drug resistant organisms (e.g., Methicillin-Resistant Staphylococcus Aureus) and other complications such as the development of clostridium-difficile infection, which may predispose the person to prolonged treatment potential hospitalization and may pose a threat of infection to other residents. (Also refer to F881 for antibiotic stewardship program for infection assessment tools.)

NOTE: Standards of practice may be revised and updated over time.

One current professional standard of practice that addresses criteria for use of antibiotics for UTI's, includes:

"Minimum criteria for initiating antibiotics for an indication of urinary tract infection were considered for residents with no indwelling urinary catheters and for residents with chronic indwelling catheters.

1. 2. For residents who do not have an indwelling catheter, minimum criteria for initiating antibiotics include: $>10^5$ CFU/mL (positive)or pending urine culture and dysuria alone or two or more of the following: fever (>37.9ºC [100ºF] or 1.5ºC [2.4ºF] increase above baseline temperature on two occasions over last 12 hours), new or worsening urgency, frequency, suprapubic pain, gross hematuria, costovertebral angle tenderness (flank pain), urinary incontinence, or shaking chills.

2. For residents who have an indwelling catheter or a suprapubic catheter), minimum criteria for initiating antibiotics include the presence of: $>10^5$ CFU/mL (positive) or pending urine culture and one or more of the following: fever (>37.9ºC [100ºF] or 1.5ºC [2.4ºF] increase above baseline temperature on two occasions over last 12 hours), new costovertebral tenderness, rigors (shaking chills), or new onset of delirium."Reference - Loeb M, Brazil K, Lohfeld L, et al. Effect of a multifaceted intervention on number of antimicrobial prescriptions for suspected urinary tract infections in residents of nursing homes: cluster randomised controlled trial. BMJ. 2005;331:669. [PMC free article] [PubMed]

NOTE: Reference - Loeb M, Brazil K, Lohfeld L, et al. Effect of a multifaceted intervention on number of antimicrobial prescriptions for suspected urinary tract

infections in residents of nursing homes: cluster randomised controlled trial. BMJ. 2005;331:669. [PMC free article] [PubMed]

Follow-Up of UTIs

The goal of treating a UTI is to alleviate systemic or local symptoms, not to eradicate all bacteria. Therefore, a post-treatment urine culture is not necessary but may be useful if UTI signs and symptoms continue or do not respond to antibiotic treatment. Continued bacteriuria without residual symptoms does not warrant repeat or continued antibiotic therapy. Recurrent UTIs (2 or more in 6 months) in a noncatheterized individual may warrant additional evaluation (such as a determination of an abnormal post void residual (PVR) urine volume or a referral to a urologist) to rule out structural abnormalities such as enlarged prostate, prolapsed bladder, periurethral abscess, strictures, bladder calculi, polyps and tumors.

Recurrent UTIs in a catheterized individual should lead the facility to look for possible impairment of free urine flow through the catheter, to re-evaluate the techniques being used for catheter care and for perineal hygiene including the removal of fecal soiling, and to reconsider the relative risks and benefits of continuing the use of an indwelling catheter.

Because the major factors (other than an indwelling catheter) that predispose individuals to bacteriuria, including physiological aging changes and chronic comorbid illnesses, cannot be modified readily, the facility should demonstrate that they:

- Employ infection prevention and control practices (e.g. Standard Precautions) in managing catheters and associated drainage system;

- Keep the resident and catheter clean of feces to minimize bacterial migration into the urethra and bladder (e.g., cleaning fecal material away from, rather than towards, the urinary meatus), however, routine perineal care with an antiseptic is not recommended;

- Maintain free urine flow through any indwelling catheter; and

- Assess for fluid needs and implement a fluid management program (using alternative approaches as needed) based on those assessed needs.

FECAL INCONTINENCE

Fecal incontinence (FI) involves the unintentional loss of solid or liquid stool. A resident experiencing FI may experience feelings of shame, embarrassment, loss of independence, may tend to isolate himself/herself creating a decrease in social interactions/activities due to fear of “accidents” with associated odors, leakage and soiling of clothing or furnishings. It is important for the facility and the attending practitioner to complete a comprehensive assessment and determine, with the resident/representative, potential

treatment and care plan interventions, and to provide ongoing evaluation of the response to those interventions. The resident should be re-evaluated whenever there is a change in bowel function. If the resident has FI that has already been investigated, documented, and determined to be irreversible or not significantly improvable, additional studies may be of limited value, unless there has been advancement in available treatments.

Risk factors for Fecal Incontinence

Risk factors for FI may include, aging and dependency in daily activities, smoking and pulmonary disease, arthritis in adults over 75 years of age, older adults with rectal cancer, comorbidities such as kidney disease, transient ischemic attacks in men, women with arterial hypertension, acute stroke (FI may depend on the severity of a stroke), functional dependency and need for assistance with toilet access 3 months after stroke in men and women, and poor general health and dementia.
http://archive.ahrq.gov/downloads/pub/evidence/pdf/fuiad/fuiad.pdf

Assessment:

To ensure that a resident who is incontinent of bowel receives appropriate treatment and services, the facility must conduct an assessment to identify the presenting symptoms and type of FI, including the potential reversible/irreversible causes and risks. Symptoms or types of FI may include (as noted in http://s3.gi.org/physicians/guidelines/FecalIncontinence.pdf):

- "**Passive incontinence** —which is the involuntary discharge of fecal matter or flatus without any awareness. This suggests a loss of perception and/or impaired rectoanal reflexes either with or without sphincter dysfunction;

- **Urge incontinence** — which is the discharge of fecal matter or flatus in spite of active attempts to retain these contents. Here, there is a predominant disruption of the sphincter function or the rectal capacity to retain stool; and/or

- **Fecal seepage** — which is the undesired leakage of stool, often after a bowel movement with otherwise normal continence and evacuation. This condition is mostly due to incomplete evacuation of stool and/or impaired rectal sensation. The sphincter function and pudendal nerve function are mostly intact".

Causes and Treatment of Fecal Incontinence

For reference, the following potential causes and treatments of FI have been adapted from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to address the long term care setting. For the full description of causes and treatment for FI, refer to:
https://www.niddk.nih.gov/health-information/digestive-diseases/bowel-control-problems-fecal-incontinence/

Potential causes for FI may include:

- Diarrhea;
- Constipation Muscle Damage or Weakness;
- Trauma, childbirth injuries, cancer surgery, and hemorrhoid surgery;
- Nerve Damage;
- Loss of Stretch in the Rectum;
- Childbirth by Vaginal Delivery;
- Hemorrhoids and Rectal Prolapse;
- Rectocele and;
- Inactivity

Potential treatment/interventions for FI should be based upon the type of FI. Potential treatment options and interventions may include:

- Eating increased amounts of fiber;
- Drinking sufficient liquids;
- Use of medications to develop more solid stools that are easier to control;
- Pelvic Floor Exercises and Biofeedback that strengthen the pelvic floor muscles may improve bowel control. Success with pelvic floor exercises depends on the cause of fecal incontinence, its severity, and the person's motivation and ability to follow the health care provider's recommendations;
- Surgery may be an option for fecal incontinence that fails to improve with other treatments or for fecal incontinence caused by pelvic floor or anal sphincter muscle injuries;
- Electrical Stimulation also called sacral nerve stimulation or neuromodulation, involves placing electrodes in the sacral nerves to the anus and rectum and continuously stimulating the nerves with electrical pulses.

Care Plan

For the resident with fecal incontinence, the care plan must reflect the results of the resident's assessment and include resident specific interventions for any potential

reversible causes and, if irreversible, appropriate interventions for management of fecal incontinence. Interventions and the provision of care should address treating the resident with respect, enhancing dignity and self-worth and reducing embarrassment and shame in relation to FI. Based upon the increased risk for transmission of infection resulting from fecal contamination, the care plan should also identify the PPE appropriate for use during the delivery of care.

Complications Potentially Related to Fecal Incontinence

Complications related to fecal incontinence may include, but are not limited to, emotional distress, loss of self-esteem, social isolation, physical complications such as skin irritation/excoriation, itching, pain, and in addition, frequent loose stool may be an indicator of fecal impaction.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F690, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- Provide appropriate and sufficient services and assistance to:
    - Maintain bladder continence and/or bowel function in continent residents; or
    - Restore bladder continence and/or bowel function as possible, based on a comprehensive assessment and clinical condition; or
    - Prevent urinary tract infections to the extent possible;
- Ensure that a resident is not catheterized unless required by his/her clinical condition; or
- Ensure that a urinary catheter is removed as soon as possible unless the catheter is necessary because of the residents' clinical condition.

INVESTIGATIVE PROTOCOL

Use

Use the Bladder and Bowel Incontinence Critical Element (CE) Pathway, and/or Urinary Catheter and UTI CE Pathway, for the condition being evaluated, along with the above interpretive guidelines when determining if the facility provides the necessary care and services to meet the resident's needs.

Summary of Procedure

Briefly review the most recent comprehensive assessments, comprehensive care plan and orders to identify whether the facility has assessed and developed an individualized care plan based on professional standards of practice and provided by qualified, competent staff. During this review, identify the extent to which the facility has implemented interventions in accordance with the resident's needs, goals for care and professional standards of practice, consistently across all shifts. This information will guide observations and interviews to be made in order to corroborate concerns identified.

NOTE: In addition to actual or potential physical harm, always *observe for visual cues of psychosocial distress and* consider whether psychosocial harm has occurred when determining severity level (See *guidance on Severity and Scope Levels and* Psychosocial Outcome Severity Guide *located in the Survey Resources zip file located at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes*).

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

An example of Severity Level 4 Noncompliance Immediate Jeopardy to Resident Health or Safety includes but is not limited to:

- The facility failed to ensure that a resident who entered the facility with an indwelling catheter was assessed for removal of the catheter as soon as possible, resulting in the resident continuing to have the catheter in place for three weeks and developing a urinary tract infection, leading to sepsis. The facility failed to provide appropriate treatment and services for a resident with fecal incontinence, resulting in the resident having severely excoriated and ulcerated areas of skin around the rectal area, with odor, and purulent exudate. The resident expressed severe pain and refused to leave her room.

Examples of Severity Level 3 Noncompliance Actual Harm that is not Immediate Jeopardy includes but is not limited to:

- The facility failed to assure that a resident who entered the facility with an indwelling catheter was assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization is necessary. During the survey, a resident was identified as having an indwelling urinary catheter in place for several months. The resident was currently being treated with an antibiotic for a symptomatic urinary tract infection. Staff interviewed were unable to provide the clinical indication for use for the catheter, and the record did not contain documentation for the initial use of the catheter or for the continued use of a urinary catheter. The resident was unable to be interviewed, but his representative was interviewed but did not know why the

catheter was in place, except that the resident had a problem with incontinence. Record review indicated that the resident had experienced repeated complications such as recurrent symptomatic UTIs which required treatment with antibiotics.

- The facility failed to assure that a resident who was incontinent of bladder received the appropriate treatment and services to restore continence to the extent possible. A resident was identified as incontinent of bladder. Based upon the resident's assessment and identification of the type of urinary incontinence, the facility developed interventions for a restorative program to restore continence. However, based on observations, staff were not implementing the interventions on the care plan, did not respond to the resident's request for assistance with use of the bathroom, and were not monitoring the progress of the interventions. The resident stated that she was frustrated and embarrassed regarding the odors and wetness that occurred as a result of the incontinence episodes. She also stated that she did not attend activities or go for meals as she needed close access to the toilet, and that she didn't want to be around others when she had incontinent episodes. She stated that she felt that she was not improving with her bladder continence, and that it was worse now than when she started the restorative program. Staff interviewed stated that they were aware of the program, but they were not able to implement the program, consistently on all shifts, as they had other resident's and duties assigned during their shifts and were unable to respond. The record reflected a decline in continence since the program began. (Also cited at sufficient staffing at F726)

Examples of Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy include but are not limited to:

- The facility failed to provide appropriate treatment and services for care of a resident with a clinically-justified indwelling catheter. During observations of care for a resident with an indwelling catheter, urine was noted to be leaking. Staff interviewed stated that they were not sure why the catheter leaked, but that they kept the resident as dry as possible. In addition, it was observed several times throughout the survey, that the catheter drainage bag and tubing were placed directly on the floor in the resident's room. There were no indications of skin maceration and/or irritation, or symptoms of a UTI symptoms.

- The facility failed to provide appropriate treatment and services for care of a resident who had intermittent fecal incontinence. During the survey, a resident was observed to stay in her room, did not attend activities and had meals served in her room. The resident was identified as alert and aware of her care needs. She stated that she had problems with intermittent fecal incontinence and was on a bowel management program that included extra fiber and liquids. She stated that recently there were changes in meal service and she was not receiving the extra fiber. She also stated that staff were to assist her with hygiene when incontinence episodes occurred, but they had not consistently provided the care. She stated that